



GLOBALIZATION & HEALTH

A qualitative study of immigrant women's
health and the Hispanic paradox

Julianna Cirafesi

Advisor: **Dr. Kari Jensen**, Department of Global Studies and Geography
Committee: **Dr. Veronica Lippencott**, Department of Global Studies and
Geography, and **Dr. Martine Hackett**, Department of Health Professions

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I. Introduction

1. Background

Globalization, which refers to the increasing economic, political, cultural, and technological connections between societies, has an impact at the local level through the migration of people. According to the *International Migration Report* published by the United Nations (2017), “The number of international migrants worldwide has continued to grow rapidly in recent years, reaching 258 million in 2017” (“Key Facts,” para. 1). This increased interaction between people is having a complex and unprecedented effect on public health, as people exchange and adapt various health behaviors. The World Health Organization has found that increasing migration leads to epidemiological and health system challenges in part because many migrants must pay out of pocket for healthcare services (Refugee and migrant health, n.d.). To complicate this global process even further, health behaviors are shaped by culture, which is a complex and nuanced topic to study.

All of these elements, namely globalization, migration, public health, and cultural behaviors, are intertwined in a phenomenon known as the healthy immigrant effect. This effect refers to the phenomenon by which the immigrant population in the United States and certain other countries is healthier than the native-born population, sometimes ascribed to self-selection into the country by healthier migrants (Abraído-Lanza et al., 2005; Kwak, 2016; Neuman, 2014). This benefit is demonstrated and supported by a variety of epidemiological data, which also reveal that the benefit decreases the longer the immigrant stays in the US and with each subsequent generation that is born in the US. Considering that the US hosts 50 million international migrants, the highest number of international migrants in one country worldwide

(*International Migration Report*, 2017), this process has a significant impact on and implications for the health of the country.

This phenomenon has also been shown to be surprisingly true for the Hispanic population. They tend to have a lower socioeconomic status overall, which would typically be associated with poor health; yet they maintain a better health status for a period of time before their health declines to even out with the US standard (Balcazar et al., 2015; Fox et al., 2015). This has been labeled the “Hispanic paradox,” a clear example of how place and health are inextricably linked. More specifically, this shift demonstrates how acculturation to the US has a negative impact on this population’s health. Given the increasing rate of noncommunicable diseases worldwide (World Health Organization, n.d.), rather than infectious ones, health behaviors and how culture and thus acculturation affects these behaviors is of increasing importance.

2. Purpose, Importance, & Relevance

Upon beginning my research into globalization and health, I found that a lot of researchers were intrigued by the Hispanic paradox and were hypothesizing about possible causes for it, then conducting various quantitative studies based on their hypotheses. What I found surprising and a bit strange, was that there were very few qualitative studies where researchers went into the community and asked for the community members’ perceptions of the situation. Because of this, I decided that the most appropriate type of study to conduct was a qualitative study whereby I asked members of the community directly about their personal, lived experiences related to health behaviors and problems. How could we know the underlying causes of the Hispanic paradox or the healthy immigrant effect if we do not ask those in the community what they know the issues to be? How could we know what they find to be the most significant

health behaviors and issues in their community? This is why I chose to sit down with women, actual members of the community that these phenomena are impacting and find out what is really going on. They are the ones who hold the knowledge.

The Hispanic and Latino population in the US is increasing, in part due to high fertility rates of women already living in the US, but also due to more immigration (Afable-Munsuz & Brindis, 2006). This population already makes up the largest ethnic minority group in the country (Siega-Riz et al., 2014). Because of this, finding where the breakdown of health in the Hispanic population is occurring is crucial. It has serious public health implications for the coming years. Because my study focuses on women, it has particular value for the intergenerational decline because of how important maternal health is for subsequent generations. In addition, my study looks at the health of first-generation US born Americans, who are the generation that could stop the decline because they are the ones that get to choose which behaviors and values to pass on from their immigrant parents to their second-generation American children.

This is a topic that is relevant for everyone, not just immigrants, not just people who are Hispanic, and not just members of the US public. The results of this study reveal important health behaviors and their association with cultural factors that could contribute to everyone's health and should be taken into consideration when determining personal and public health choices. In addition, I have chosen to use globalization as a lens, allowing it to guide my research and assist me in finding useful connections in my data. Because of this, my research has the purpose of not only shedding light on public health issues, but also on the impact of globalization at the local level.

3. Clarification & Justification of Terminology

There are various terms which I must justify the use of and clarify the use of throughout this paper. The term “Hispanic” has been used in different ways and is sometimes replaced by terms like “Latino” or “Latinx.” For the purposes of my paper, I have defined “Hispanic” as referring to the Spanish-speaking population. I have chosen to use this term, as opposed to any other in order to remain consistent with health data, which often uses “Hispanic” as a category. Additionally, my study only includes Spanish-speaking people, whereas terms like “Latino” could include people who are from any of the Latin American countries, regardless of language. I also find “Hispanic” to be a less controversial and more inclusive term because it is non-gendered.

Use of the term “first-generation Americans” (which most participants in my study identified as) in this paper refers to people whose parents are immigrants, but were themselves born in the US. However, because some of my participants were born abroad and moved to the US at a very young age, I prefer to refer to the whole group as the “in-between generation” particularly because I consider their role in the intergenerational decline of health so crucial. I also use “country of origin” by which I am referring to the ethnic background of the participant, not simply the country in which they were born. Another important note is that authors I have cited often use the term “first-generation immigrant” which refers to the actual immigrant themselves, not first-generation Americans.

Lastly, I need to clarify use of the terms “healthy immigrant effect” and “Hispanic paradox.” Other terms sometimes used include “Latino paradox.” For my purposes, including the purposes of the authors I cite, the Hispanic paradox is used in relation to the healthy immigrant effect, so it refers to the intergenerational decline specifically. In addition, I consider the

Hispanic paradox to be a sub-category of the healthy immigrant effect, whereas some other authors use a different framework, but ultimately refer to the same effect.

II. Globalization & Health

Globalization is a well-known concept in relation to technology, communication, trade and politics, but it is less often recognized as the culprit of global health changes. Peter Koehn (2006) notes that “Unprecedented migration, a core dimension of contemporary globalization, challenges population health” (“Abstract,” para. 1). With hundreds of millions of people crossing international borders annually, it is apparent that there is going to be a significant, unprecedented impact on public health around the world. Although the focus of Koehn’s research is on how to educate future healthcare professionals on transnational competence and consultations, there is still a lot we have to learn from these lessons. In a broader sense, what we should take away from this is the increasing complexity of health as the world becomes more globalized. A variety of disciplines, especially the field of public health, need to be looking toward the future to prepare for the effects that globalization will have.

One such way in which globalization affects health is through changing nutrition around the world, as described in a study by Himmelgreen, Cantor, Arias, and Daza (2014). These changes occur due to sub-processes of globalization, such as Westernization, dietary delocalization, and changing agricultural policies that are all backed by neoliberal policies often pushed by the West (p. 79). The authors also emphasize the complexity of the relationship between globalization, acculturation, and nutrition transition. They caution us to not oversimplify this relationship, stating that the results of the processes together are “neither lineal nor direct and that the role of social and physical environments, culture, social organization, and technology must be taken into account to better understand this relationship” (p. 77).

Additionally, though they emphasize the huge impact that acculturation can have on health, they point out that the term does not have a solidified definition and that it can refer to both the complete loss of cultural identity or less extreme cultural adaptation, modification, and exchange (p. 80).

III. The Healthy Immigrant Effect

The healthy immigrant effect is one example of how globalization is an international process that impacts people at the local level. Various studies have been conducted to demonstrate how the healthy immigrant effect holds true for a variety of health conditions. One such study, conducted by Miller, Robinson, and Cibula (2016), found that the healthy immigrant effect could be applied to preterm births of both immigrant and refugee women. They chose to look at this health indicator specifically because having a full-term birth indicates much better health outcomes for the child in the future. The authors used birth records of residents in Syracuse, NY which has a high refugee population. Immigrants and refugees reported lower median earnings than the US-born population, which would typically suggest worsened health outcomes for the foreign-born population. However, infants born to immigrants and refugees had “decreased risks of being born preterm compared to infants born to US mothers” (p. 485). This is especially interesting because refugees are exposed to a greater number of risk-factors to their health, such as the physical and mental effects from war (p. 485). The authors point out that “Increased global instability will likely create more refugees seeking asylum in the US” so it is crucial for this topic to be studied on a deeper level to ensure that we can prepare for the public health issues we may face (p. 492).

In another study, Ramraj, Pulver, and Siddiqi (2015) conducted a systemic review and meta-analysis to determine if the healthy immigrant effect holds true in terms of birth weight

across generations in the UK and US. The authors found that “at the individual level, being a second-generation (or greater) immigrant mother resulted in a statistically significant increase in odds of having a low birth weight child when compared to being a first-generation immigrant mother” (p. 34). This means that a child is more likely to have better health outcomes if it is born to a foreign-born mother (note: when the authors say “first-generation immigrant” they are referring to the person who actually immigrated), as opposed to one who was born in the US herself. These findings are very important because “birth weight is cited as the single most important indicator of neonatal and infant survival and has been strongly linked to later development of chronic diseases and other adverse health outcomes” (p. 29). Similar to other literature I have found, these authors suggest that their results could be due to negative acculturation. However, this study had major limitations, including that some of the data was from studies that were tainted by recall bias, meaning that participants may have inaccurately remembered or reported certain information.

IV. The Hispanic Paradox

1. [Explanation of the Paradox](#)

The Hispanic paradox, which for my purposes will be considered a sub-category of the healthy immigrant effect, has a variety of implications for the health of the US population. Although some studies claim to provide evidence against the existence of this paradox, an overwhelming majority of the research demonstrates that it is a phenomenon that occurs across an array of health issues and various locations in the US.

A study by Page (2007) examined health behaviors and attitudes toward pregnancy that are associated with negative pregnancy outcomes. The aim of the study was to determine possible behaviors that could be the cause of the Hispanic paradox. The data was taken from the

National Survey of Family Growth (p. 300). Aspects analyzed were substance use, sexual behaviors, health services utilization, pregnancy wantedness, attitude toward parenthood, maternal/gender roles, and acculturation. In terms of acculturation, the distinction was made between women who were more comfortable speaking English (classified as more acculturated) and those who were more comfortable speaking Spanish (classified as less acculturated). The less acculturated Hispanic women were less likely to be employed, had lower incomes, were more likely to not have health insurance, and “were more likely to be married or living with their partner” than the other groups (p. 304).

The results of this study demonstrated a significant difference in attitudes and behaviors between less acculturated Hispanic women and the other groups, including Hispanic women who were more acculturated. The findings showed that the less acculturated Hispanic women were less likely to use substances like tobacco during pregnancy and were less likely to partake in risky sexual behaviors. These women also had more traditional values regarding pregnancy such as feeling happy to be pregnant and believing that women should stay home and take care of children while the husband works (p. 310). The study suggests that these cultural factors could have a protective effect on the health of the women during pregnancy. Limitations of the study are that it cannot infer causality and it is challenging to measure acculturation, but this study represents a good basis on which to determine actual behaviors that are contributing to the Hispanic paradox, rather than simply finding that it does exist (which is what a lot of the literature does).

In a study conducted by Giuntella (2016), the author confirms the Hispanic paradox and emphasizes the generational decline of health in Hispanic people in the US. Guintella found that “Children of first-generation Hispanic immigrant women have lower incidence of low birth

weight and heavier average birth weight than children of US born white women” (p. 88). Specifically, overall the birth weights were found to be much healthier. These findings also demonstrate that with each generation of Hispanic immigrants that stay in the US, their birth weight advantage declines.

Guintella’s study is particularly meaningful because she uses longitudinal data about birth weight as an indicator of birth outcomes. The data was gathered from the Office of Vital Records of the California Department of Health and the Bureau of Vital Statistics of the Florida Department of Health. Demographic information was gathered from the US Census. These three databases are very reliable, making her study dependable in terms of this specific aspect of intergenerational health trajectories. It is also important to mention that the author did find differences in birth weights between Hispanic countries. Children with parents from Mexico and Cuba had healthier birth weights than children of white mothers, while children of Puerto Rican origin had less healthy birth weights than children of white women (p. 88).

The validity of the Hispanic paradox is relevant, not just for those of Hispanic origin, but for all ethnic groups in the US. The relevance of this paradox is explained by a study conducted by Shaw and Pickett (2013) which analyzed birth outcomes in areas with high-density Hispanic populations. The authors found that “Living in counties with a higher proportion of Hispanic residents was associated with a lower risk of infant mortality and maternal smoking during pregnancy for black and white mothers” (p. e3). Living in these counties was also associated with lower risk of low birth weight for all groups. These findings suggest that living in a high-density Hispanic community may have a protective effect on health. Based on these findings, as well as previous literature that focused on actual causes for the paradox, the authors suggest that it could be because Hispanic communities have high social capital despite often having low

material capital (p. e5). This means that the social capital could be helping improve health outcomes of all members of these communities, regardless of ethnicity.

Although there is a significant amount of literature that supports the Hispanic paradox, there are a few studies that suggest its supposed existence is just the result of inaccurate studies. One such study was conducted by Smith and Bradshaw (2006). The study is a bit outdated as it does not account for research in support of the paradox that has been done in the past 12 years. The focus of Smith and Bradshaw's research was on mortality. They analyzed existing data about births and deaths in Texas and found that there was no significant difference in mortality for Hispanics and non-Hispanic whites. They calculated age-specific death rates and ultimately came to the conclusion that "There is no "Hispanic paradox"" (p. 1).

However, during the course of my literature search, I found a multitude of studies that did not make the mistakes Smith and Bradshaw claim are the reasons for the Hispanic paradox. The mistakes they cited were the salmon bias (whereby people return to their country of origin to die) and only choosing participants from higher socioeconomic statuses and better health. In addition, Smith and Bradshaw looked at death rates and life expectancy broadly, whereas there is a lot of literature that demonstrates the validity of the Hispanic paradox for specific health issues, none of which Smith and Bradshaw acknowledge.

[2. Specific Health Behaviors](#)

The Hispanic paradox has been studied in connection to a variety of health behaviors and conditions. Cagney et al. (2007) analyzed this paradox (they used the term "Latino paradox") in relation to respiratory issues, such as asthma. What is particularly unique about this study is that the authors looked at how the paradox held up in different neighborhood compositions. What they found was that foreign-born Latinos had a significantly lower prevalence of respiratory

conditions than other groups. However, this only remained true if they resided in a neighborhood composed of a high number of foreign-born residents. Foreign-born Latinos who resided in neighborhoods with few foreign-born residents actually had the highest prevalence of respiratory problems. This study demonstrates how strong the protective factor of a cultural community may be. This is significant because it could suggest that the paradox only applies to certain neighborhoods. There needs to be further analysis on what else differentiated these communities (such as the pollution level, housing conditions, and other factors affecting respiratory health).

Obesity is of even more critical concern for the Hispanic population in the United States. Yeh et al. (2009) state that “Hispanic American women in particular have higher rates of obesity than their non-Hispanic counterparts” (p. 105). With this as their main concern, the authors decided to look at the role that acculturation plays in the obesity issue. They suggest that one way to intervene would be through selective acculturation, whereby Hispanic American women are encouraged to preserve health behaviors and discard detrimental ones. However, this could be challenging considering the difficulty and ethical issues with changing someone’s cultural behaviors.

Although Yeh et al. do not specifically mention globalization, they allude to it through their discussion of dietary transitions around the world. This is a very important point. Countries are beginning to adapt dietary habits similar to the United States. This change is problematic because it could mean that there will be no more healthy behaviors to preserve through selective acculturation, as the authors suggest as an intervention tactic. This shows how truly global this issue and topic is.

A study by Siega-Riz et al. (2014) also looks at obesity issues, specifically in the context of food-group and nutrient-density intakes. Unlike many other studies, these authors analyzed the

data by more specific ethnic backgrounds. Instead of grouping all “Hispanics” or “Latinos” together, they divided groups by categories like South American and Central American. The authors’ results demonstrated that Puerto Ricans had the highest prevalence of cardiovascular disease (CVD) and CVD risk factors. South Americans had the lowest prevalence. This shows that it can be important to categorize participants more narrowly when looking at specific health behaviors. Though worth mentioning because of how it breaks down groups more narrowly, this approach can also be impractical for certain studies, considering that most census data and epidemiological data is broken down into more broad categories. In addition, there are reasons for the grouping—the Hispanic population in the US has adopted some similar behaviors, including from each other. They tend to move into communities with each other and remain in similar socioeconomic positions.

An article by Fox et al. (2015), “Intergenerational Transmission of the Effects of Acculturation on Health in Hispanic Americans: A Fetal Programming Perspective” is worth mentioning in this review. It offers a biological, evolution-based framework for studying the intergenerational decline of health in this specific population, whereas many other studies suggest behavioral and social frameworks. No other literature that I found mentioned this type of framework. Fox et al. suggest that the acculturation process that Hispanic immigrant women experience could be negatively impacting the development of their unborn children through fetal programming. Essentially, negative effects from what the mother experiences during pregnancy could significantly impact the fetus while in the womb, to the point that it causes a detriment to the child throughout its life. Unfortunately, studying the Hispanic paradox using this framework would be quite challenging. However, it is a relevant and important possibility to consider since

it would suggest that public health interventions be implemented much sooner in order to prevent the decline of health.

On the other end of the spectrum, there are various social reasons associated with the decline of Hispanic immigrant populations' health. Social stressors are often believed to negatively impact the health of the Hispanic population. Rojas et al. (2016) gathered qualitative data from focus groups to determine what family stressors could be at play in Hispanic immigrants. The authors identified three main themes in these immigrants' families' lives that are causing significant stress. First, the participants noted that they felt an obligation to move to the US in order to help their families, typically for economic and educational opportunities. However, they made this decision knowing that it could also hurt their families in some ways, due to leaving their families in their home country, learning a new language, etc. Rojas et al. note that this theme relates to the documentation that the Hispanic population places a lot of value and importance on sacrifice, specifically for their families. Essentially, it all comes down to the idea of the "perception of hurting family to help the family" (p. 413).

The second theme that the authors extrapolated from their data was the "intergenerational breakdown of family goals and dreams" (p. 413). The participants felt that their children did not pursue or take advantage of the very opportunities for which the parents had made sacrifices. This was incredibly upsetting to the participants since they felt that they had sacrificed so much. Rojas et al. note that the likely reasons for this were not that the children were lazy or unappreciative. Rather it is more likely that conditions out of the control of the immigrants' children, such as neighborhood atmosphere, hindered their ability to pursue the opportunities that their parents wanted them to.

The third theme, which the authors label as “forced shifts,” has multiple components. It refers to the immigrant women feeling overwhelmed by the pressure to provide financially for their families, while also fulfilling the traditional role of wife and mother. This theme also refers to the shifting role of immigrants’ children whereby the older children have to take on a bigger, somewhat more parental role. For example, they may have to act as an intermediary between their family and the new cultural system that they must operate in. This study as a whole is important in understanding the immense stress that immigrants are under. They often experience much different stressors than their US-born counterparts, meaning that mental health interventions must be planned differently.

A study by Lee (2012) specifically looked at the mental health of two Hispanic groups, Puerto Ricans and Mexicans. Lee studied how residential segregation and isolation of ethnic groups correlated with the status of these groups’ mental health. To measure isolation, she used the “isolation index” which scores the probability that members of a group will meet other members of their same group (I.e. not those of other ethnic backgrounds in this case). In other words, isolation refers to an ethnic group’s isolation from other ethnic groups and/or mainstream society. Lee found no significant association between mental health and isolation for Puerto Ricans, but found adverse effects for Mexicans who lived in more isolated communities. These results are in direct opposition to what research shows in terms of physical health and isolation, whereby Hispanic groups have better health when they live in closer, more isolated cultural communities. Lee suggests that the demand for conformity and excessive bonding could be the reason for the negative impact on mental health and not on physical health. However, this is curious considering the significant effect that mental health has on physical health, which would suggest that these two effects would cancel each other out in a sense.

Mental health is closely related to alcohol use. Latino teens born in the US have higher rates of alcohol use than those who are foreign born, which supports the Hispanic paradox. Bacio et al. (2012) studied how certain factors related to family closeness and peer pressure impacted these rates of alcohol use. The authors found that “early drinking initiation and problematic alcohol use were more prevalent among later-generation youth” (p.1). In addition, “generation significantly predicted number of alcohol-related problems,” with third generation youth having the highest rate of problems (p. 5). Bacio et al. found that family values are likely a protective factor for alcohol issues in adolescents. With each subsequent generation, the family closeness appeared to decline.

VII. Methodology

1. School of Thought

My research is based in the school of thought of feminism. The idea behind this school of thought is that research was, and sometimes still is, dominated by men (Kitchin & Tate, 2000). This school of thought emphasizes that knowledge is socially constructed and that research has largely reflected men and those in power. The aim of the feminist critique is to take a sociopolitical stance in research in order to empower and emancipate vulnerable populations (Kitchin & Tate, 2000). Feminist critique closely matches the goal of my research because I intend to provide an outlet for women to share stories about their lives and then use these stories to show the value of their personal experiences. In addition, feminist critique seeks to acknowledge and change the power relations in society, which aligns with my topic because of the perceived lack of power that immigrants have in our society (Kitchin & Tate, 2000). Furthermore, my research is inherently sociopolitical due to the current political climate, negative rhetoric, and heated debates about immigration, which is in part what inspired me to

choose this topic. In addition, it is my hope that policy decisions as well as personal behaviors may change and be guided by some of the information elucidated throughout this paper.

2. Methodology

Feminism is not only a school of thought, but also a methodology. I used feminist methodology because it emphasizes the need to let the participants' voices be heard. It is not my place to act as the voice of the women I interviewed, but rather create a space where their voices could be heard. Feminist methodology is a form of a mixed method approach that is based in paying close attention to social injustices and has an explicit agenda for social change (Thien, 2009). One of the preferred practices for feminist methodology is to conduct in depth interviews because it allows for the researcher to truly listen to the participants, who are often members of vulnerable populations that are misunderstood or underrepresented in academic literature. It gives them the ability to tell their own stories. It was crucial when using this method that the women's voices produced the knowledge for my research and that they were treated as authorities over their own experiences, as well as over the body of knowledge that they produce.

I have also chosen to use feminist methodology because it rejects the idea of the researcher as a neutral observer (Thien, 2009). I believe that researchers always have an agenda that they are trying to achieve and it is best to be explicit about this, instead of pretending it does not exist. I must, of course, be mindful of how the political climate and recent events related to immigration have influenced my opinion on the topic as I do not want my bias to inappropriately guide my research. However, I have found sufficient evidence in the existing literature that the healthy immigrant effect and the Hispanic paradox are issues that need to be addressed. This allows me to now focus on and determine how women perceive these phenomena and their health behaviors, which will hopefully spark increased discussion and research on the topic and

impact healthcare decisions for immigrants, as well as people born in the US. For this aspect of my research, my research questions were: What personal experiences have members of the group in question had in relation to their health and health of their families?

In addition to feminist methodology, I used case study methodology to examine the case of the Hispanic population on Long Island. Essentially, case study methodology calls for an intensive analysis of a certain place and/or group of people (Hardwick, 2009). The idea is to get a deeper understanding of a specific situation. Case study methodology works well for my research because Long Island has a diverse population, with a large number of Hispanic immigrants. More specifically, I used exploratory case study methodology, which seeks to investigate a specific topic and set a foundation on which more research can be based (Hardwick, 2009). For the purpose of my research, the exploratory questions were: How do Hispanic women of the “in between” generation perceive their health? What health behaviors are occurring in the Hispanic communities in the US that could be contributing to the Hispanic paradox? Using exploratory case study methodology leaves the door open for my research to be used as a starting point for more expansive studies with quantitative methods that can demonstrate direct causation of certain health behaviors to the Hispanic paradox and could provide definitive public health intervention strategies.

Case study methodology sometimes involves a mixture of qualitative and quantitative data (Hardwick, 2009); however, my research is based entirely in qualitative methods. I have chosen to only use qualitative methods because the purpose of my research is to share personal experiences and knowledge, not to prove that the Hispanic paradox is occurring. Qualitative research is utilized with the understanding that results are not generalizable, but rather illuminate specific stories that are useful in understanding certain situations. As mentioned, there is

sufficient evidence to demonstrate that the Hispanic paradox is occurring, therefore my purpose is rather to figure out what health behaviors could be the cause of it and how Hispanic women of this specific demographic perceive their own situation.

Based on these two methodologies, feminism and exploratory case study, I conducted interviews with Hispanic women. To find my participants, I used purposive sampling (also known as judgement sampling) and snowball sampling. These are both types of nonprobability sampling. The former refers to choosing participants based on subjective, but logical decisions about who best represents the population that is being studied (Battaglia, 2008). The latter refers to the process of identifying additional participants from existing participants and so on (Lewis-Beck, 2004). I found my first few participants through existing contacts of mine who knew of women who fit the specific criteria. Those participants then put me in touch with additional women.

The initial age criteria for participation was between the ages of 18 and 35. This age range was chosen because it was likely that women of these ages would be old enough to have observed and understood themselves and their families' behaviors, but young enough to still be developing their own culture, including their beliefs about and behaviors of health. It was also very important for participants to be at least 18 years old due to the additional, complicated ethical considerations and more time-consuming Institutional Review Board approval process that would have been necessary if the participants were minors. Ultimately, the participants were all between the ages of 18 and 27 (the average age of the participants ended up being approximately 22 years) and were either born in the United States or moved to the United States no later than the age of four. Each participant had an ethnic background from one of five Spanish-speaking Latin American countries. It is worth noting that these five countries were

relatively geographically close to each other. Participants all currently live on Long Island, although some had lived in US East Coast states other than NY for an extended period of time. Their parents were born in a Spanish-speaking Latin American country and immigrated to the US no earlier than the age of 16. I specifically and exclusively interviewed women because women's health is directly related to the health of subsequent generations (largely through maternal health). Therefore, this was the most important group to study when looking at a phenomenon such as the Hispanic paradox, which involves an intergenerational change.

I conducted seven in-depth, semi-structured interviews. The general structure on which the interviews were based was as follows: basic demographic information and cultural identity, personal health behaviors, personal history of health problems and conditions, demographic information of parents, information about parents' move to the US, mothers' health behaviors and problems, explanation and discussion of the healthy immigrant effect and the Hispanic paradox, concerns or comments about the interview. I specifically chose to not mention the healthy immigrant effect or the Hispanic paradox until near the end of the interviews. I wanted to make sure that the participants were telling me what they felt was important, not what they necessarily thought supported or opposed the phenomena in question. Then, toward the end, I asked each participant if they had heard of these phenomena. If they had not, I explained it to them so that they could then tell me if anything came to mind in relation to what I had just described.

Interview questions were designed to allow the women to have the opportunity to tell me what they believe is most important. However, the format of the questions also allowed me to guide the interview in a direction that would ultimately be most beneficial to understanding the health behaviors of this specific population and how the Hispanic paradox is or is not impacting

the population in question. Because of the semi-structured nature of the interviews, the length of the interviews varied from approximately 40 minutes to nearly three hours.

After transcription of each interview, each transcript was analyzed by extracting broad topics from the interview. Data was then organized into an excel sheet where it was further broken down into smaller categories and cross-checked with demographic and cultural information about the participants. From this point, major themes and relationships between health behaviors and conditions and participants' characteristics were found. Important quotes and storylines were also identified and extracted.

3. Ethical Considerations & Procedures

The Hofstra University Institutional Review Board approved my research under expedited procedures. After having informed each participant about the overall topic of my research, I obtained informed consent from them to confirm that they fully understood the interview process and that there would be no compensation for participation. At the beginning of each interview I also reminded the participants that they could stop the interview at any point and could choose to skip over specific questions. This was especially important due to the extremely personal and sometimes upsetting nature of the topics in question. In order to ensure confidentiality, I assigned participants with new names, which I used both in my notes and in this paper. Specific country names were omitted in this paper to protect participants' identities, as well. For the same reasons, sometimes participants were not referred to by any specific name at all in this paper so that not all information could be fully connected (and therefore make it easier to figure out the participants' identities).

In addition, because of the intent of my research and the ethical consideration to not exploit or take advantage of my participants, I asked each woman at the end of the interview if

she wished to be contacted once I am able to share my findings. I believe that it is important that I share my findings with the women who I interviewed because they are the ones who have produced the body of knowledge (this belief is based on writings of Dowling, 2009). I also have chosen to not publish my research until I have received approval from my participants stating that they are comfortable with the information that will be made public and that they do not feel that they would be identifiable by what is revealed in this paper.

4. [Positionality](#)

Although I, in my position as the researcher, do not have a specific relationship to Hispanic women, I do have some level of bias because I am a woman and exclusively interviewed women. Because of this, it is possible that I was more sympathetic to their cause and more likely to trust what they said. The activist sociopolitical nature of feminism, which is both my school of thought and methodology, will inevitably impact my perception of the situation of these women because I believe there to be many injustices occurring in relation to immigration and women's rights. Feminism specifically suggests that action should be taken based on a sociopolitical stance (Thien, 2009).

Because I engaged in this research as an outsider to the culture of my participants, it was important for me to be especially aware of the issues surrounding cross-cultural research. Not only am I from a different ethnic group, but I also interviewed some women who were immigrants, including undocumented immigrants, which puts them in a perceived position of vulnerability. In addition to this being an important element of conducting my research in an ethical manner, feminist methodology calls for the researcher to pay attention to power relations, including that of the researcher and the participants (Thien, 2009).

VIII. Results & Discussion

1. Participant Characteristics & Cultural Elements

Five of the seven participants were born in the US (specifically in states on the East Coast). Only two of the participants were born in a Spanish-speaking Latin American country. I completed a round of analysis to determine if this fact influenced any of the other factors or health behaviors. Aside from Ariana, who came here undocumented, I found no evidence that birthplace played a role. I will discuss factors relating to Ariana's immigration status in subsequent sections.

These seven women came from slightly different socioeconomic backgrounds, but most consider themselves to be lower middle class. However, there was some variation within the sample. All participants had either completed a university degree or were in the process of obtaining one. Participants all had health insurance throughout most of their lives, with three of them utilizing Medicaid at various times. None of the participants felt that they ever had a lack of access to healthcare services. The situation was quite the opposite for their parents. Many of their parents were uninsured and avoided going to the doctor because of the expense. Some parents did attend clinics targeted at low-income and immigrant populations.

All of the participants believed that their parents' reasons for coming to the US were for educational and economic opportunities. Many participants mentioned their parents coming here to pursue "The American Dream." Almost all participants perceived their parents as being happy with their decision to move to the US, despite significant financial concerns and health problems. Their parents moved to the US between the ages of 16 and 33 years.

All participants were raised Christian and all but one were raised Catholic. However, two of my participants have grown away from their religious backgrounds as they have gotten older. Regardless, all participants saw religion as playing a big role in their lives because it is

such a big part of their culture and has shaped their belief systems. They also strongly associated family closeness and the importance of family with their culture. Cohesion and closeness of their communities was also associated with these values. The most negative characteristic that they associated with their culture was the largely patriarchal nature of it, which they found had begun to dissipate with acculturation.

All participants cited Spanish as their first language, except one who learned English and Spanish simultaneously. Although some participants mentioned identifying more strongly with US culture or their parents' cultures, all participants identified with both cultures and practiced elements of each in their daily lives. Some, more than others, struggled with this dual identity. I found that this contributed to certain uses of language. For example, one participant noted that the term "gorda" has particularly been a source of conflicting feelings for her. Although the term means "fat", it is often used as a term of endearment in some Hispanic cultures. However, because this participant's mind operates both in Spanish and English, and in both US culture and the culture of her country of origin, she finds herself sometimes upset by being called "gorda." Another interesting trend I noted with language was how participants used "we" and "they" when talking about people of US culture and the culture of their country of origin. There was no consistency about when they referred to a cultural group as "they" (which would suggest that they were distancing themselves from that group) and when they used "we" (which would suggest that they associated closely with that group). This, again, speaks to the dual identity of the participants.

2. Food Culture, Nutrition, & Physical Activity

The most significant theme of my results, which every single participant specifically emphasized, was the role of nutrition and food culture in their health and the health of their

families. Participants noted that foods from their countries of origin in Latin America were much fresher, less processed, and generally healthier. Although some did note that their cultural food contained a lot of fried elements and sometimes excessive amounts of rice and corn, they all tended to find it healthier than fast food, which they associated as a big part of US American culture. Gabriela recounted the story of her family coming to the US and not knowing where to find ethnic foods or fresh foods, so they ended up eating fast food quite often. She told me that her mother's very first meal when she came to the US was a burger from McDonald's. Another participant, Ana told me that in her home country in Latin America, people selling fresh foods would go door to door each day, making these foods much more accessible to the general population.

Ariana told me "Especially in the [area I come from] we have a lot of organic food that we grow; it's all from the earth—there's obviously no preservatives or additional supplements... because it's all from the earth. We grow our own food... we sustain ourselves. There's no intermediate... so I definitely agree that we're healthier than the United States in a lot of cases." However, in line with the health decline evidenced by the Hispanic paradox, Ariana also noted that once her family moved to the US, for financial reasons they sometimes had to buy food in bulk, which was always processed and much less healthy. She noticed that a lot of families in her community also had to do this.

Aside from the differences in actual nutritional value of the foods, I found the pre-immigration food cultures to be extremely different than the food culture of the US. It appears to contribute to the immigrants' decline in health when they stay in the US. Of course, the food cultures were different for each Latin American country and varied within each country; I do not want to generalize and make it seem that they are all the same. Two participants (interestingly

both from South American countries) noted that their traditional foods were healthier than even other Latin American foods (specifically ones from Central America). This discrepancy between Latin American cultures is similar to those noted in Siega-Riz et al. (2014). That said, I found more similarities than differences among the food cultures of the participants. They also often ate foods from various other Latin American cultures, which inevitably blended with and became part of their own food cultures.

In addition, food, for the women I interviewed, was often a family event—food was fresh, home cooked, and shared amongst the whole family. Daniela also emphasized the emotional value of food in culture, “I think it made my mom feel good that I loved her food so much and I love her so much and she was doing this for our family, even though I knew how tired she was. And it was always kind of like a disrespect if she would come home and we wouldn’t eat her food.” Similarly, Ariana said:

I think [cooking] was a very major thing for my mother and her mother and the relationship that they had...And it's not just because you're the woman and you have to cook. It's like it's an art and it's something you want to pass down. And now the way Mom cooks things that's the way I cook it out of respect for her. And she learned from her mother and she passed it down.

These two stories demonstrate the significant value that food has in these cultures. The social value of food likely has positive effects for the health of people in these cultures.

However, as participants’ families became more acculturated, the difference between the traditional food culture and US culture began to change and blend with other cultures. Their families began to eat foods outside of their own cultures. Sofia mentioned that her mother had begun cooking foods like burgers and lasagna. Sofia also said that her parents had actually explicitly mentioned that they feel worse health-wise in the US than they did in their home country. They specifically attributed it to changes in their dietary habits. Many participants also

mentioned that since attending college, their dietary habits had changed significantly, having gone from eating traditional foods cooked by their parents, to eating whatever was available—typically less healthy, less cultural foods.

This combination can also be understood through Daniela's family's eating habits. Daniela told me that her mother cooks often because "in [culture of origin] the wife cooks all the time. So my mom would cook Monday through Friday and it would be like big dishes, like traditional [culture of origin] dishes and on the weekend it was more like we could get wings or fries or burgers or whatever fast food that we wanted." She also said that some members of her extended family actually ate fast food quite consistently. They would eat "Dunkin Donuts in the morning, McDonald's for lunch" every day of the week. Daniela observed that this led to significant weight gain and a decline in the health of these family members. This directly relates to Yeh et al. (2009) and their recommendation to consider selective acculturation as a counter measure to increasing obesity levels in the Hispanic community in the US.

Participants also noted the role of physical activity in health. Many participants were encouraged to play sports or dance as children, which they associate with positive health. A couple of participants specifically noted the importance of soccer. They described it as an important part of their culture—the family would gather to watch the games on TV, as well as play together outside. This method of physical activity was important to them, even after they began to acculturate more to US culture. This is one way in which the Hispanic community appears to maintain a healthier lifestyle, since physical activity is actually ingrained in their culture and practiced as part of social gatherings. A couple of participants also noted that in their countries of origin, walking was a much more common mode of transportation. Daniela drew attention to her one cousin who was very fit while he was living in their home country. However,

she notes that “Here [in the US] he started driving and he was sitting a lot. He didn't do much, it was like work, home, sit on the couch, eat eat eat and go for beers.” This was a common theme in participants’ families; they ate less healthy foods and had less physical activity (aside from sometimes physically demanding jobs), both resulting in weight gain.

3. [Mental Health](#)

Mental health was also a very strong theme in my results. My findings are aligned with what the results in the study by Lee (2009) suggest—essentially that the Hispanic paradox may not be true in terms of mental health, rather it may only impact physical health. The two main elements of this theme that I would like to discuss are the underlying causes of mental health and the lack of discussion around the topic within the Hispanic community. To begin, I found that there was some continuity across the data as to reasons for mental health issues. For participants themselves, the main stressors were financial/work pressure and social problems. Ariana, Daniela, and Isabella all mentioned serious instances of bullying during their childhood, which was detrimental to their social and psychological well-being. Ariana’s anxiety was exacerbated by this situation to the point that she experienced anxiety-induced hallucinations. Participants cited elements such as body weight, clothing style, and having an accent as reasons for why they were bullied.

Daniela was caught in a bit of a viscous cycle whereby she was picked on for being overweight, then ate to comfort herself, but then was, of course, picked on even more. For Daniela, the most emotional she became during the interview was when she mentioned feeling pressure from her own father to look a certain way, particularly to look very thin like her sister. She often sought his approval throughout her teenage years as she began to exercise more and try

to become skinnier. This has had a lasting impact on her mental health, though she appears to be in a much more stable condition now, both mentally and physically.

In terms of financial and work pressure, all participants currently had a job, internship, or were taking college courses, all of which were often a cause of stress. Many participants had jobs since they were in their early teenage years. Isabella's work and financial situation in particular had a serious detrimental impact on her mental health. While taking a full load of college courses, she worked three jobs in order to support her family. Her dad had recently lost his job and her mom was battling an illness that made it too difficult for her to work. Isabella and her family almost became homeless at one point due to the extreme financial stress they were under. Somewhere during this time period, she also experienced abuse from a boyfriend. Considering these circumstances, it is not hard to see how unstable her mental health was at this time.

Participants perceived their parents' stressors to be largely due to financial/work pressure, familial situations, and adjusting to a new location. Ana noted that her mother did not want to move to the US. Her father, who she described as "the traditional head of the family" made the executive decision for their family to make the move. Ana's mother had to leave all of her family behind in her home country. Shortly after moving to the US, Ana's mother was diagnosed with depression, directly related to the move. Rojas et al. (2016) clearly describe this type of decision whereby the parents (typically the father) make a decision to move the family, knowing that it will hurt them in certain ways, but coming to the conclusion that ultimately it will be better for them. For the one making the decision to move, it is a worthwhile sacrifice, though it is not always seen as such by the other members of the family.

Ana also mentioned that her father played a big role in the state of her mother's mental health because her father had aggression issues which impacted their marriage. Related to Ana's

parents' situation, but a bit more extreme, Sofia mentioned issues of domestic violence between her parents, and Maria mentioned her father cheating on her mother. Many participants' parents dealt with familial separation, as well. Specifically, many of them left close family members behind in their country of origin, with some even leaving their entire families behind. All of these factors played a significant role in the parents' mental health, as perceived by their children.

Considering the amount of mental health issues that the participants and their parents dealt with, it is surprising how little it is discussed. The participants noted that talking about feelings or mental health was specifically not part of their culture. Ana told me that she could not tell her mom about her feelings at all and Gabriela stated, "I think in my culture in general mental health is very taboo. Like you don't talk about being sad. We don't talk about feelings." Even Isabella, while she was going through extreme financial instability, felt pressure to not discuss how she was feeling because "someone else was always going through something worse."

Sofia explained to me that her family does not even accept that mental illness is real, much less something that needs to be discussed. She said:

They think mental issues are not real and they won't take it seriously. Even like one of my aunts, she went through depression and a lot of my family was saying how it was like fake, mental issues don't exist. And she was really going through depression. I was always telling them "How do you know it's not real?" So I feel like they just wouldn't take it seriously.

Although not officially diagnosed, Sofia has experienced some issues with anxiety, namely panic attacks brought on by the stress of work and school, which she has not been able to tell her parents about. She states, "I have to hide it all the time. And especially because [my parents] didn't get the chance to have the education that I do or the opportunities that I do, I just always

have to put on a strong face.” Participants’ parents felt very strongly about the importance of education and often put a lot of pressure on their children to do well in school, which participants noted could be detrimental for their mental health. Essentially, because these parents sacrificed a lot for their children to have better opportunities, it has caused so much pressure on their children that it has negatively impacted the children’s overall well-being. This finding, again, is closely related to the findings of Rojas et al. (2016) which analyzed “intergenerational breakdown of family goals and dreams” (p. 413). Specifically, according to my participants, their parents felt that their children were unappreciative of their sacrifices. Although it was clear to me that Sofia and other participants were grateful to their parents, it is apparent that there is a gap in communication that leads to the way that the parents and children perceive and experience the situation.

Ariana has an additional, unique concern in terms of mental health and overall well-being. Ariana is a “dreamer”, one of the beneficiaries of the Deferred Action for Childhood Arrivals policy (DACA). She told me that because of President Trump’s new policies, she has had to have some very challenging discussions with her family about the possibility of being deported or having to move to Canada. The potential consequences for their mental health in this situation are concerning, as they could not only become separated from a country they have lived in for nearly two decades, but they may be separated from each other. This demonstrates how policies that are not directly healthcare policies, do impact the health of the population.

I would like to end this section with an exceptionally perceptive statement from Isabella. This statement was made after I explained the healthy immigrant effect and the Hispanic paradox to her and she immediately brought up how the US lifestyle is detrimental to health, especially in

terms of the extreme stress of the lifestyle and its impact on mental health. Isabella noted of the decline of immigrants' health:

I think honestly it has to do mostly with two things: one is the lifestyle in the US—we're taught to work like dogs. The harder you work, the more money you'll have. The harder you work the more prestige you'll have. And though it's a beautiful concept and I appreciate it with everything that I have because it's what led me to [where I am] today. I also don't like it because... I'm not getting home 'til 7:30 or 8pm every day. I leave my house at 8am. And my weekends go so fast. Whereas in [country of origin], I always talk to my aunts over there and my cousins; they have more of a life. For them it's so important to make sure you come home, like be inside your house, by 5. They take siestas between 12 and 1pm. They value mental health, indirectly, way more than the US does. Like we [in the US] talk about it, we advertise it, we even put it on a pedestal as like a way to say "Oh my god it's such a fantastic thing to do and like achieve" but I don't think they [in the US] really understand the importance of the background, which is like why are we here in the first place, why are we mentally unable to be happy, why are we so anxious, why are we so stressed... I alluded mostly to the lifestyle that we live and also the importance that this country puts on money.

I find this to be a particularly astute observation because it eloquently shows her perception of the relationship between US lifestyle, mental health, and why we, as a society, are failing to solve the issue of declining mental health. Isabella's statement touches on an element of mental health that may be beneficial to study more, as it may provide a lesson that the entire US population needs to learn.

4. Alcohol

Although all of the participants considered themselves to be social drinkers, many participants had one or more family members, typically male, who had serious issues with alcohol. Often, this resulted in trouble in these male family members' home lives, as well as their overall health, and the mental health of their spouses and children. Although some participants noted that alcohol was a part of their culture back in their country of origin, they also said that the drinking was reinforced or worsened by the stress of the US lifestyle. Specifically, participants believed it was related to the hectic environment in the US, especially in NY, as well

as economic stressors. Ariana also mentioned the relationship between alcohol and violence, including gang violence, which she often witnessed in her community while she was growing up. Ariana emphasized the relationship between alcohol and mental health as well, stating, “The pressures of adjusting to a new culture and working really shitty jobs for very long hours and physically laborious—that takes a toll mental health wise and I know it took a toll on both my parents because they grew up having those dreams and aspirations.”

Additionally, Ana mentioned the role alcohol played in the death of a close family member. Although she does drink socially, she said that she mostly avoids alcohol because of the negative role it played in her family’s life. Sofia also mentioned multiple male family members of hers who were alcoholics, including a family member who died from complications of his alcoholism. Sofia also noted that in the town in the US where she grew up “it was just very normal to drink at a young age.” This contributed to Sofia’s decision to start drinking at a young age. Other participants also mentioned that drinking at a young age was prevalent in their communities, and generally in the Hispanic community overall. These findings are consistent with the information reported by Bacio et al. (2012). There were a couple of mentions of alcohol in a positive context, mostly in terms of social events, but the tone around the topic was largely negative, with alcohol playing a very detrimental role in the participants’ homes and communities.

5. Sexual Health & Behaviors

I found little variation among the sexual histories of the participants. Nearly all participants had partaken in premarital sex, but all of them exclusively had sex with people they were close to—either a long-term romantic partner or a close friend. There was no mention of casual sex or sex with a large number of partners. None of the participants were married, though

three of them were in serious, monogamous romantic relationships, which involved sexual activities. All participants mentioned the role of religion and culture in relation to sex, pointing out that premarital sex was considered “wrong” but that they had come to terms with their personal decision to have sex. One participant who has engaged only in very limited sexual activity, cited religion and fear of pregnancy as reasons for not having sex. She expressed to me that there were a lot of cases of teen pregnancy in her family and she did not want to be in that situation.

Participants noted that they typically used condoms for intercourse. That said, many had occasionally chosen not to use condoms because their sexual encounters were with people they trusted and therefore they felt less fear of contracting a sexually transmitted infection (STI) or becoming pregnant. One participant did have an accidental pregnancy, which she chose to abort—a decision that she did not take lightly and was emotionally challenging for her because of her conservative cultural and religious background. Another participant noted having to take the “day after pill” in a last-minute attempt to prevent pregnancy, which was successful. However, overall, participants did not partake in very risky sexual behaviors, which they said was largely influenced by their cultural and religious backgrounds.

Similar to mental health, sex was a topic that participants told me was not acceptable to talk about in their culture. Often, participants said that their parents knew they were having premarital sex (largely due to parental intuition), but because their parents were not supportive of it, they avoided the conversation entirely. Sofia noted about talking about sex, “I know like in a typical American [family] you’re comfortable talking about that kind of stuff with your mom, but for me, no.” She says she wishes she could talk with her mom about it. Ana also noted:

I can’t go up to my mom and say something because it’s like if it contradicts Catholicism in any way, it is wrong. It’s not going to be “Hey Mom, I have a boyfriend” [because

Mom will say] “Are you having sex? Sex is wrong. You can’t have premarital [sex].” And it’s a big thing, my dad was the same also. He wasn’t as much religious, but he had the traditional cultural aspect that didn’t allow all that.

This sentiment expressed by Ana was what the majority of the participants had experienced.

In contrast, one participant and her family have slightly more liberal views about sex, the most liberal views out of all the participants. This participant’s mother had discussed safe sex practices with her and was aware of her decision to have premarital sex. Although raised Catholic, neither this participant nor her boyfriend identifies themselves with any religion. The participant also noted that her mother is not a very religious person. This correlation between religious ambivalence and sexual openness is likely not coincidental and is directly linked with the acculturation process. She also appeared to be the most acculturated of the participants, being the only one to not consider Spanish her first language. Rather, she said she learned English and Spanish simultaneously.

6. Living Conditions

For many participants, living conditions were not conducive to fostering good health. Three participants mentioned living in basements when they were younger. Two of the three associated living in a basement with worsened health, specifically respiratory issues that they have experienced throughout their lives, beginning around the time of living in basements. I found this living condition to be especially challenging for Ariana who had lived in a house in a rural area, likely with much cleaner air, before moving to the basement conditions. If immigrants are moving from a healthy environment into a basement while their children are young, then this could be having significant effects on their health throughout their lives and could be why the health of their community declines with each generation. It should also be noted that none of the participants that mentioned respiratory conditions reported that they or the family members they

lived with smoked cigarettes or any other substances. My findings around respiratory problems in these participants may contradict those of Cagney et al. (2007) because their findings suggest that low prevalence of respiratory conditions in foreign-born Latinos occurs in communities with high percentages of foreign-born residents. Although my participants did live in communities with high percentages of foreign-born residents, they were not themselves foreign-born and the effect with the in-between generation has not been thoroughly studied.

Participants mentioned troublesome living conditions due to a couple of other factors. They were sometimes forced to live in very cramped situations for financial reasons. Daniela told me that at one point her family of four was sharing one bedroom. Though their apartment had two bedrooms, the other bedroom was occupied by even more extended family members. However, Daniela and the rest of the participants who did not mention basement conditions, all reported decent conditions of the housing units themselves. At the time of the interviews, most participants were living in safe neighborhoods and in quality houses or apartments.

The environment of the neighborhoods that the participants lived in was also often concerning. Of the participants, Ariana and Isabella mentioned the most extreme and detrimental environments. More casually than one would expect, Ariana explained that as a child, she often played with the daughter of a gang leader. Her community was full of sex offenders and gangs resulting in her often hearing gunshots throughout the night. Isabella also lived in an area with a lot of violence, which she associated with the high number of immigrants in the area. Although she often felt that the members of her neighborhood were nice people, she said that they brought “baggage” with them from their home countries. There was lots of crime and her car was robbed very frequently. In addition, members of the US Immigration and Customs Enforcement Agency (typically known as ICE) were constantly in her building, creating a constant sense of fear and

instability. These conditions created a high level of strain on Ariana and Isabella's mental health, though they were not always aware of it at the time. Ariana specifically mentioned that those conditions were the norm for her, so she only realized how extreme the situation was in hindsight. Regardless, this strain on their mental health likely impacted their physical health in ways that are not necessarily apparent currently.

7. Working Conditions

Participants at the time of the interviews, were mostly working in good conditions. Many had paid internships or were working in safe office environments. However, they had experienced some negative situations, typically as teenagers. The main issue that participants encountered was working long hours and being underpaid. Ariana also experienced a bit more extreme situations in which her superiors were misogynistic and had ignorant perceptions of her because she is an immigrant. Isabella, as mentioned in the section on mental health, was forced to work multiple jobs and was under an extreme level of stress because of it. Participants said they put up with mistreatment and undue burden from their jobs for financial reasons; they often really needed to keep their jobs.

Although participants themselves did have experiences with concerning work conditions, as I have just explained, they more strongly emphasized the circumstances and conditions in which their parents worked. Ariana told me how incredibly intelligent her parents are and how highly educated her father is. Her father has a degree in a highly technical field from his country of origin, but because he is undocumented and because degrees from other countries are often not taken seriously in the US, it has been impossible for him to get a high-paying job in his field. Instead, both of her parents have had to work multiple jobs at a time. These were always jobs below their pay grade.

Similarly, Ana and Isabella have highly educated mothers who had prestigious careers in their home countries. Upon arrival to the US, they took lower-level jobs due to their status as an immigrant (even if they had documentation) and the language barrier. Ana also mentioned that her mother did not like her former career, as it had been forced on her by her mother's father, who wanted her to have a prestigious career. Isabella's mother's career shift was especially drastic—she went from having clothes sewn specifically for her in her home country, to being forced to learn to sew in order to work a factory job.

Aside from a few of the participants' parents, who worked slightly more technical jobs, most of the parents worked jobs typically considered "menial labor." These jobs included babysitting, cooking, cleaning, gardening/landscaping, and factory work. Because these jobs are so physically demanding, they resulted in a number of injuries for the parents, namely cuts, burns, carpal tunnel, and back problems. Participants also noted that their parents worked very long hours and sometimes worked multiple jobs. The participants observed that their parents would come home from work completely exhausted and were only able to spend limited amounts of time with their children because they were so busy and tired. A few participants even mentioned that their parents were so busy that the children had to be raised or babysat frequently by other family members (often grandparents) or family friends.

8. [The Next Generation: Cultural Traits & Health Behaviors](#)

All participants said that they would like to have children (with some hesitation from just a few). Because of this, I asked them what elements of culture and which health behaviors they want to pass on to their children. I also asked them to describe any of these elements or behaviors that they specifically do *not* want to pass on. The main theme here was that

participants wanted to be much more open with their children about sex and mental health. As mentioned in the sections on mental health and sexual health, most participants felt frustrated and upset by the lack of communication around these topics. Because of this, Sofia plans to have conversations about sex and mental health with her younger sibling, as well as her own children.

Most participants also emphasized that their children must learn Spanish—not necessarily as a first language, but certainly at an early point in their childhood. However, Ana was particularly firm about this—she insisted that their first language must be Spanish. Perhaps the most conservative of the participants in this particular context, she also wants her children to attend Catholic school and adopt many traditional values (aside from the lack of communication around sex and mental health). All participants wanted to pass down some of these traditional values, specifically in terms of family. They emphasized how crucial it was for their children to value family as much as they do.

All participants also want to pass on some elements of their food culture, though most mentioned wanting to include foods from other cultures as well to ensure ultimate healthfulness of their diet. As mentioned in the section on food, Ariana noted how food is an art form, so it is a crucial element of what she wants to pass on to her children. Daniela seemed to want to pass on food culture as well; however she emphasized that she did not want to pass on patriarchal culture to her children. She said, “If I have a girl I'm going to teach her that you can do anything a guy can do. And if it's a boy I'm going to be the same way. It's like you can do anything a girl can do. Like definitely stop genderifying things.” One additional point of interest that a participant brought up is how it will be hard to decide what to pass on because she is in an intercultural relationship. She and her boyfriend will likely have to find a balance between their multiple

cultures. This is another way in which the acculturation process happens and potentially contributes to the Hispanic paradox.

The findings in this section are particularly meaningful and relevant to the Hispanic paradox. The participants seem to be choosing to pass on cultural values and health behaviors that would be positive for their children's health, not cause an intergenerational decline. This leads me to believe that either previous generations did not make similar choices about what to pass on to their children; or, more likely, external factors, like the ones I have mentioned in the living and working conditions section, as well as the fetal programming framework suggested by Fox et al. (2015), are preventing the healthy choices from being achieved.

9. Observations of Participants' Reactions

I observed no negative reactions to the questions that I asked my participants. Rather, I found participants to be incredibly open and willing to share their experiences, much more so than anticipated. I asked extremely personal, and perceivably uncomfortable questions—about their sexual behaviors, mental health, parents' divorces, and even domestic violence. Yet no participant fully shied away from these questions. There were moments of slight hesitation and occasionally participants had to take a step back, breathe, and sometimes even take a moment to cry. However, ultimately, they seemed to actually want to discuss what they had gone through. Daniela told me that some of what she said, she had never really said out loud before. This demonstrates that we need to be asking these types of questions more often. Many participants told me they wished there was an outlet for them to talk about these problems.

In terms of the explanation of the healthy immigrant effect and the Hispanic paradox, I also found participants' reactions to be quite positive. Although two participants thought they may have heard of the terms, none of them had a full understanding of these phenomena. Toward

the end of the interviews, right after I explained the terms, all participants had a bit of a “lightbulb moment” whereby they put together their ongoing observations of their communities and found the epidemiological data to make sense. It seemed that they were relieved and excited to learn that this was an actual term and phenomena supported by hard evidence for something they had noticed occurring in their own communities.

IX. Conclusion

My findings reveal a fast decline in the health of the women I interviewed and their families, much faster than most of the previous literature that I have reviewed would suggest. The decline appears to occur very soon after the immigrants arrive, not just in the subsequent generations. Chronic stress, discrimination, social isolation, and other consequences of acculturation impact the participants’ and their families’ mental and physical health. Although initially the Hispanic population in the US tends to have higher social capital and lower material capital (Shaw & Pickett, 2013), which may balance each other out initially, there appears to be an erosion of the social capital of my participants and their families as they stay in the US due to a combination of the aforementioned factors. Specifically, working long hours and demanding jobs can result in social isolation, both from their communities and their families. Compounding this is the fact that they are often separated from much of their family who remained in their country of origin. All of this also puts a strain on the parent-child relationship as the children feel a large amount of pressure from their parents to work extremely hard in school and have successful careers to make their parents’ sacrifices worthwhile.

In terms of physical health, acculturation is a major factor as some of the women and their families began eating less traditional foods and more unhealthy US cultural foods. Some of them also adopted a more sedentary lifestyle, which they associated with US culture, as opposed

to their cultures of origin which often supported a more active lifestyle ingrained with soccer and other physical activities. However, I found that the most important contributing factor to both the decline in mental health and physical health was the stressful nature of the US lifestyle, which is exacerbated by the additional challenges they face as immigrants, such as discrimination, economic pressures, and poor housing conditions.

Even so, my results reveal that there is certainly no singular explanation for why the Hispanic paradox exists in the group of women I interviewed and why the health of this population declines so drastically. Future studies must be careful to use a well-rounded framework to consider all the possible factors. Given the current political climate, it is also important for future studies to look at how contemporary immigration laws, imposed by the Trump administration, are impacting the health of immigrants. My hope for my own research is that it will shed light on some of the issues that are occurring in this specific community, as well as demonstrate what we can learn from the Hispanic community to help improve the public health situation in the US. It is important moving forward that there are quantitative studies that look at each of the particular themes described in my results and analyze appropriate public health measures to stop the decline in health and preserve healthy behaviors, while eliminating the problematic ones.

I found that there is still a lot to learn and there is a lot to fix. Given the challenges of the current political climate, as well as the somewhat unpredictable effects of globalization it will be interesting to see in the coming years whether the healthy immigrant effect will change or diminish. If Latin American countries, like the ones my participants' families come from, become more "Westernized" or "Americanized," will the health behaviors that are positive and better than health behaviors in the US decline? Will the Hispanic paradox fade away? I cannot be

sure of this, but my findings reveal a variety of stories, which illuminate health behaviors and situations that are important to study further. My results can help to facilitate the design of future, more expansive qualitative and quantitative studies and hopefully contribute to improving global health.

Despite the serious and upsetting nature of much of my results, it is not all gloomy! There is hope in this and in the possibility of the whole US population becoming healthier with what we have to learn from immigrants. I want to emphasize the resilience of the immigrant and Hispanic communities; the stories of perseverance, hard work, and community cohesiveness that my participants shared with me were inspiring and nothing to take lightly. Ana described the members of her culture as having an amazing work ethic and being determined, perseverant, generous, kind, and compassionate people. In addition, Hispanic immigrants have much to offer the US—labor, skills, amazing food, and perhaps most importantly, a reminder of the value of family and community.

X. References

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